Occupational therapy graduates of 2009: knowledge and attitudes relating to their role in the area of alcohol misuse

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Purpose: Within Scotland, health policy changes are being considered to address the misuse of alcohol. Concurrently, a shifting of professional roles within the National Health Service is under way. The purpose of the study was to investigate personal knowledge and attitudes relating to alcohol use/misuse amongst all final year Scottish occupational therapy students.

Procedure: A self-completed questionnaire was developed for delivery in spring 2009 within scheduled lectures to students (n = 161) at all three Scottish universities providing occupational therapy education.

Findings: Of those in class, 93% (n = 109) provided completed questionnaires. There was evidence of gaps in knowledge around the understanding and application of United Kingdom responsible drinking guidelines; however, students reported confidence in their professional and personal ability to act effectively in this area of clinical practice. There was a distinct lack of congruence with key proposals put forward by the Scottish Government to address alcohol misuse.

Conclusion: Identified knowledge gaps have implications for the alcohol teaching content of the curriculum in Scotland. Additionally, while investigation of student attitudes revealed a self-belief in personal and professional skills, the findings nevertheless stress a need to ensure that the potential value of occupational therapists' contribution is more effectively communicated to their health professional colleagues.

Introduction

Societal costs associated with alcohol drinking in Scotland have been estimated at £3.56 billion per annum (Scottish Government 2010). According to Scottish Health Action on Alcohol Problems (2007), 90% of the adult population drink alcohol and it is unsurprising, therefore, that Scotland has witnessed significant increases in alcohol-related ill health and death in recent decades (ISD Scotland 2009).

The need to respond to the toll that alcohol exerts on both the individual and society has been prioritised by health professionals and politicians alike. Against a background of government-driven alcohol policy changes, and the concurrent overlapping of professional responsibilities within the National Health Service (NHS), this study contributes to the description of the occupational therapist's role in this important area of practice. It describes the knowledge, views and perceptions of soon-to-graduate Scottish occupational therapy students.

Literature review

A brief literature review was performed using the following search terms: students; alcohol; professional role; knowledge; attitudes; alcohol and occupational therapy. The inclusion criteria were English language, published

between 1985 and 2010. The databases searched were CINAHL, Medline, PsycINFO, EBSCO, British Nursing Index, Web of Science, SCOPUS and the NHS e-library.

Occupational therapy and alcohol

Current health statistics continue to highlight the associated costs of Scottish drinking habits and, with some justification, they feature regularly in both media and political agenda. Occupational therapists are among the health care professionals who work with people who misuse alcohol. Helbig and MacKay (2003) explored addictive behaviours from an occupational perspective and considered addiction in relation to occupational risk factors, flow and boredom. They suggested that addiction is occupational in nature and can lead to occupational disruption.

The role of occupational therapy in working with people who misuse alcohol has been discussed by several authors: Stone (1985), Cassidy (1988), Moyers (1988), Nixon (1988), Stensrud and Lushbough (1988), Clarey and Felstead (1990), Booth and Mulligan (1994), Cornvinelli (2005), McQueen and Allan (2006) and McQueen et al (2006). Most of these studies focus on how occupational therapists work within specialist addiction units and mental health units. While some work was conducted over 25 years ago, much information is still pertinent. The studies include a United Kingdom (UK) survey (Nixon 1988) and narrative accounts of intervention (Stone 1985, Cassidy 1988, Moyers 1988, Nixon 1988, Stensrud and Lushbough 1988, Clarey and Felsted 1990).

Counselling and the use of counselling skills are highlighted in four articles, along with occupational therapists working with clients to reduce their reliance on alcohol by incorporating occupational techniques into their daily life. The therapeutic relationship is also considered important (Stone 1985, Cassidy 1988, Clarey and Felstead 1990).

More recently, a review of interventions for people with substance use disorders was undertaken by Stoffel and Moyers (2004). Four effective interventions are identified: brief interventions, cognitive behavioural therapy, motivational strategies and 12-step programmes. Suggestions for occupational therapy are that interventions should be modified to include an occupational perspective, leading to occupationally focused outcomes. In a recent study, Cornvinelli (2005) offered specific guidelines for occupational therapists when working with young men who misuse substances (including alcohol). With regard to occupation, she suggested that offering choice, discussing expectations, relating to peers, matching the client's skills to opportunities, setting achievable goals and offering clear feedback are vital for this client group.

There is some reference to the potential for the role of occupational therapy being aligned to health promotion (Cassidy 1988, Booth and Mulligan 1994). McQueen et al (2006) highlighted the potential role of brief motivational counselling techniques as appropriate interventions for consideration by occupational therapists. McQueen and Allan (2006) contended that there was a clear role for occupational therapists when working with individuals who were not classified as alcohol dependent but who were consuming in excess of health guidelines.

Implications for the profession

The argument for a clear, identified role for occupational therapy in this key area of public health brings two responsibilities. First, there must be a commitment to educate new and practising therapists appropriately, equipping them to meet the particular demands of this area of practice. Secondly, there must be a recognition of the need to promote the views and voice of occupational therapy in the area of policy development. Booth and Mulligan (1994) explored levels of educational input in relation to alcohol use. Interestingly, they concluded that 'the quantity of occupational therapy education about alcohol abuse is not commensurate with the scale of the problem' (p356). However, they advocated for a greater acceptance of the value of occupational therapy in this area of practice, including the delivery of brief interventions and representation at future policy development discussions.

Some of the concerns of these authors are voiced more recently in part of the written evidence submitted in 2008 by the College of Occupational Therapists to the policy review *Working together to reduce harm: the substance misuse strategy for Wales 2008-2018*. In this paper, the authors suggested that in the area of prevention 'there is no mention of the important contribution that occupational therapy can make' and that therapists 'could contribute far more than is currently the case in preventing addictive behaviour developing in the first place' (Crowder and Forster 2008, p2). (It is interesting to note that Booth and Mulligan's [1994] comments were made at a time when the UK societal costs attributed to alcohol were lower than those recently calculated for Scotland alone [Scottish Government 2010].)

Alcohol policy development

Current UK policy direction suggests that it may be desirable to change the drinking pattern of the majority of the population if meaningful improvements in health and health-related costs are to be gained. In its response to statistics highlighting the societal and economic costs of alcohol, the Scottish Government (2008) has recently outlined key proposals, including (i) the ending of 'the promotion and loss leading [selling drinks at below cost price] of alcoholic drinks in licensed premises', (ii) the introduction of minimum retail pricing, and (iii) a 'raising [of] the minimum legal purchase age for off-sales to 21'. In addition, (iv) there is a commitment 'to continue to call for a reduction in the drink drive limit from 80 mg to 50 mg per 100 ml of blood'.

The Scottish Government set the NHS in Scotland the target of delivering 149,449 brief interventions on alcohol between April 2008 and March 2011. NHS Health Scotland supports all health boards to meet the HEAT: H4 (Health Efficiency Access and Treatment) target for the delivery of

alcohol brief interventions locally (NHS Scotland 2008). The Scottish Intercollegiate Guidelines Network's Guidelines for the Management of Harmful Drinking and Alcohol Dependence in Primary Care (SIGN 2003) recommend brief and minimal interventions, including helping the patient to weigh up the benefits and disadvantages of his or her drinking pattern. Suggested methods are written media, motivational interviewing and case detection, as opposed to screening for the problem.

Two points are of relevance. First, the potential cost-effectiveness of brief interventions delivered in care settings (National Institute on Alcohol Abuse and Alcoholism 2005, Kaner et al 2009) and, secondly, the recent policy changes within the NHS advocating the development of flexible and collaborative working patterns for health professionals (Department of Health [DH] 2000, 2001, NHS Scotland 2002, 2003). Therefore, the onus, and by implication the potential success of delivering interventions addressing alcohol misuse, may depend on a wider range of health professionals than hitherto.

Education has responded. There has been a move towards shared interdisciplinary teaching within the health professional curricula. The World Health Organisation Study Group on Interprofessional Education and Collaborative Practice endorses and directs interprofessional collaboration in education and practice as an innovative strategy. It views it as being necessary in preparing a 'collaborative practice-ready workforce' (Yan et al 2007). It is stated that effective interprofessional education leads to effective collaborative practice.

The necessity for these ideals to be met by graduating health care professionals in this important area of health policy framed the rationale for the work presented below. The authors set out to survey a large number of medical, nursing and allied health professional students at higher education institutions (HEIs) located within different Scottish cities shortly before they graduated and entered the workforce. Given the large number of students involved, a questionnaire was designed to address the following research questions:

1. What are the levels of knowledge around current UK health advice relating to alcohol use among final year occupational therapy students in Scotland?
2. What are the attitudes of these students in relation to their professional role in the field of alcohol misuse?
3. Do graduating Scottish occupational therapists support, in principle, four key policy proposals put forward by the Scottish Government to address the problems of alcohol misuse?

The findings reported here describe pooled data collected at the three HEIs in Scotland providing occupational therapy education. At each of these, interprofessional education is embedded within the 4-year curriculum. These data are a subset of a larger study, which explored the knowledge and attitudes of graduating allied health professional, nursing and medical students at six universities in Scotland. These results are reported elsewhere (Gill et al 2010).

Method

Participants

The study was conducted during the second semester of the academic year 2008-09 at all three Scottish HEIs offering degree courses in occupational therapy, and invited participation by students due to graduate in July 2009.

Ethics

Favourable ethical opinion was obtained from each HEI. The first page of the questionnaire comprised an information sheet giving details of the study, and assurances of confidentiality and anonymity. Potential participants were assured of their right to decline participation, and informed that the results would be presented at conferences and/or appear in published form. Completion of the questionnaire was taken as informed consent.

Procedure

A paper form of the questionnaire was administered and completed at lectures.

Questionnaire

The questionnaire contained three sections. The first, *Section A*, sought basic demographic data: gender, age, undergraduate year, degree specialisation, drinker/non-drinker classification. (Non-drinkers were defined as drinking no more than '2 glasses of wine, 1-2 pints of beer per year'.) In an attempt to increase participation rates and to comply with ethical committee stipulations, no additional questions relating to personal consumption levels were included.

Section B explored knowledge relating to current UK responsible drinking guidelines for daily consumption (DH 1995) and was shaped by a questionnaire previously employed by two of the authors (Gill and O'May 2007). Accurate recall was recorded as an answer of 3, 3-4 or 4 UK units for men, and 2, 2-3 or 3 units for women (one UK unit is equivalent to 10 ml or 8 g of ethanol). Those who had indicated that they were drinkers were asked to state their preferred drink and the usual volume consumed and to estimate its unit content. From this information, and using manufacturer's product data if required, the unit content was calculated. The estimate provided by the student was then categorised as 'underestimate', 'overestimate' or 'accurate'. (For wine, an alcohol by volume of 12% was assumed.) Non-drinkers, instead, answered a general question relating to the units contained in a typical glass of wine.

Section C was influenced by the questionnaire developed by Happell and Taylor (2001) to explore nurses' attitudes to clients with drug and alcohol problems, and contained 14 statements to which participants were required to respond according to a six-point Likert scale ranging from 'strongly disagree' to 'strongly agree'. The first 10 statements related to professional role and attitude, and the final four to policy change proposals emerging from the Scottish Government's discussion paper (Scottish Government 2008).

Table 1. Summary of student responses (n = 109) to questions relating to UK responsible drinking guidelines

Responses	Percentage (n)
Provided accurate estimate of UK unit content of personally preferred alcoholic drink (amongst drinkers)	47.1% (n = 48)
Responded 'don't know' when asked the UK unit content of personally preferred alcoholic drink (amongst drinkers)	21.6% (n = 22)
Provided accurate recall of UK male daily drinking guidelines (all students)	58.7% (n = 64)
Provided accurate recall of UK female daily drinking guidelines (all students)	67.0% (n = 73)
Responded 'don't know' when asked to quote male drinking guidelines (all students)	14.7% (n = 16)
Responded 'don't know' when asked to quote female drinking guidelines (all students)	16.5% (n = 18)

The questionnaire was developed and then piloted with a group of second-year occupational therapy students. In addition, following the pilot phase, content validity was addressed by seeking comments from two practitioners working in clinical departments linked to alcohol misuse within two NHS health boards in Scotland.

Data were analysed using the Statistical Package for the Social Sciences (SPSS) version 16, with the coding and data entry of every seventh questionnaire being cross-checked.

Results

Section A: Basic demographic data

Of those eligible to take part in the study (161 occupational therapy students), 109 students completed the questionnaire (of the 117 who were present at classes on the day of the survey). Therefore, response rates were 68% for matriculated students, and 93% for those present at the timetabled class. No advance warning of the survey was given. The mean age of the sample was 25.9 years (95% CI: 22.58-27.22) and the age range was 21-48 years. Regarding gender distribution, 95.4% of the sample were female, with 6.4% (n = 5) self-reporting as non-drinkers.

Section B: Knowledge

Participants' responses to Section B of the questionnaire, exploring knowledge around UK responsible drinking guidelines, are shown in Table 1.

Among drinkers, just over one-fifth (21.6%) did not know the unit content of their personal choice of alcoholic drink. Amongst all students, approximately one-third (33%) did not know, or could not accurately recall, the UK recommended daily limits of consumption for women. For male guidelines, this figure rose to 41%. These findings are, in part, consistent with responses to the later statement, 'I feel I have the appropriate knowledge to advise my patients about responsible drinking advice and the problems associated with alcohol misuse'; over 40% (n = 44) did not agree (see Table 4).

Students' responses to the question, 'How would you define the phrase "someone with alcohol problems"?', are summarised in Table 2. Responses were grouped into three broad categories. Some respondents provided more than one definition and two did not answer this question. The greatest number of responses were in the group relating alcohol problems to the consequences of excessive intake – around half of all responses. However, it is of interest that almost two-fifths of responses related alcohol problems to amount consumed. Very few responses, 13.6%, were linked to the reasons for drinking.

Section C: Professional role/attitude, reaction to proposed Scottish alcohol policy changes

Students were asked to name the profession(s) they thought was best placed to intervene and offer advice when it was suspected that a patient had a problem with alcohol. Their responses are collated in Table 3. It is of

Table 2. Student responses (n = 109) to the question 'How would you define the phrase "someone with alcohol problems"?' (Note: students could supply more than one definition)

Categories	Comments	Number of occupational therapy responses	%
1. Comments relating to amount or pattern of intake	Drinks every day	20	
	Drinks an excessive amount	21	
	Does not know limits	1	
	Drinks more than three times a week	2	
	Drinks alone	1	
	Drinks very frequently	11	
	Drinks more than weekly limit	9	
	Drinks outside social hours	2	
		67	**37.9%**
2. Comments relating to reasons for drinking	Drinks to get through the day	12	
	Drinks to get drunk	4	
	Uses alcohol to solve problems	5	
	Can't say no to drink	1	
	Drinks whenever there is an excuse	1	
	Can't socialise without drink	1	
		24	**13.6%**
3. Comments suggesting consequences of excessive drinking pattern	Alcoholic	2	
	Dependent on drink	42	
	Drink has a negative impact on their life	21	
	Out of control – needs help	7	
	Becomes ill with drink	4	
	Addicted	5	
	Signs of withdrawal	1	
	Behaviour out of control	1	
	Always thinking about drink	1	
	Not aware of problems	2	
		86	**48.6%**
4.	No answer supplied	2	
Total		**177**	

Table 3. Professions identified by students (n = 109) as best placed to intervene when alcohol misuse suspected (students could name more than one profession)

Profession	Number of students selecting this profession
Medicine	52
Nursing	37
Social work	14
Dietitian	4
Psychologist	13
Counsellor	10
Occupational therapist	51
Nutritionist	2
'All professions'	18
Psychiatrist	3
Therapist	1
Physiotherapist	0
Pharmacist	0
Podiatrist	0
Speech and language therapist	0
Don't know	1

interest that occupational therapy was named almost as frequently as the medical profession. Also of note is the fact that 31% of students (n = 34) named only one profession, and for 10% (n = 11) this was occupational therapy. As many as 66% (n = 72) respondents listed more than one profession and 58 of those included themselves (the 'all professions' response has been included in this count).

The following professions were not selected: podiatrists, radiographers and speech and language therapists/audiologists. (It is noteworthy that in the larger study [Gill et al, in preparation] which involved other graduating health professionals including medical students [an additional 418 students], occupational therapy was selected as a response by these future colleagues only 15 times.)

The responses of the occupational therapy students to statements relating to professional role and attitude and to four key proposed changes to alcohol policy in Scotland are presented in Table 4.

A large majority of occupational therapy students agreed that their own profession had a role to play in brief interventions (although, as noted earlier, this view was clearly not shared by some of their future colleagues). A similar number agreed that early intervention was likely to be beneficial and that all professionals had a role in this area. Interestingly, while 92.5% saw a role for their profession, slightly fewer (86.2%) felt that they had the personal qualities required to initiate brief interventions, and only 58.8% felt that they had the appropriate knowledge to offer advice about guidelines. A small number (12.8%) reported possible embarrassment when asking about a patient's alcohol use. Almost a quarter indicated that in their private life they would avoid people whom they suspected had an alcohol problem.

Of the proposed changes to Scottish alcohol policy, only the change suggesting a reduction in the drink driving limit met with the approval of the majority of these students. Fewer, only around one-third of students, indicated agreement (see Table 4) for policy changes that had an impact on selling price, the banning of below cost price alcohol promotions and the changing of the legal age for off-sales purchases.

Discussion

The responses of this sample of Scottish occupational therapy students to the questionnaire capture an interesting insight into the views of occupational therapy students towards alcohol, their professional practice and the wider political debate around alcohol use in Scotland.

The students' responses concerning their ability to work with people with alcohol problems generally indicate a degree of personal confidence, and a conviction that there is a role for their profession. For example, 92.5% of students believed that occupational therapy has a role to play in brief interventions with patients when alcohol misuse is suspected, with a similar number recognising the important contribution that can be made by fellow professionals working in this area.

Similarly, the study provides evidence of optimism amongst these final year students relating to the potential impact of occupational therapy in this area of practice. The benefits of early intervention (93.6%), a belief that alcohol misusing individuals could be helped before they reached 'rock bottom' (86.1%) and a confidence that alcohol problems were not beyond the control of the person affected (72%) were supported.

Two points emerging from the study are worthy of further debate within the profession. First, while it is encouraging that 92.5% of students believed that their profession had a role in this area of practice, there is, nevertheless, a clear challenge for interprofessional education curricular content and collaborative working, for this confidence was not recognised by the other student professions. Exploration of those factors that have influenced other health professionals' view of the occupational therapist's role is merited, and may offer challenges for the professional body.

Secondly, the recall and understanding of current UK drinking guidelines was relatively poor. Only 58.8% of the occupational therapy students indicated that they had the appropriate knowledge to advise patients about responsible drinking, while 53% of those who drank either did not know, or did not accurately know, the unit content of their choice of alcoholic drink. Despite the high profile afforded to the topic of alcohol and public health within the UK, this finding has resonance with conclusions made 16 years ago by Booth and Mulligan (1994), who highlighted the lack of alcohol teaching within occupational therapy courses.

It could be argued that the newly qualified occupational therapist must be equipped with several skills to work effectively in this area of practice, and not simply have knowledge of the UK sensible drinking message (DH 1995), important as this is. In addition, interpersonal skills, empathy and sensitivity will all be crucial in this very difficult and

Table 4. Students' responses to statements around issues relating to alcohol (n = 109)

Statement	Strongly disagree	Quite strongly disagree	Disagree	Agree	Quite strongly agree	Strongly agree	Blank (n)	Overall disagree %	Overall disagree (n)	Overall agree %	Overall agree (n)
My own profession has a role to play in brief interventions when alcohol misuse is suspected in a patient	2	3	3	28	35	36	2	**7.5%**	**(8)**	**92.5%**	**(99)**
I have the appropriate knowledge to advise my patients about responsible drinking advice and the problems associated with alcohol misuse	2	8	34	44	15	4	2	**41.2%**	**(44)**	**58.8%**	**(63)**
Health professionals who identify alcohol problems early can improve the chances of treatment success	0	0	7	34	40	27	1	**6.5%**	**(7)**	**93.5%**	**(101)**
All health professionals in the UK share the responsibility of intervening when a patient is suspected of having an alcohol problem	0	1	6	31	26	45	0	**6.4%**	**(7)**	**93.6%**	**(102)**
Alcohol problems are beyond the control of the person affected	11	18	48	21	8	1	2	**72.0%**	**(77)**	**28.0%**	**(30)**
I have the personal qualities required to initiate brief interventions relating to responsible drinking	0	5	10	64	23	7	0	**13.8%**	**(15)**	**86.2%**	**(94)**
In my private life I would avoid people whom I suspect to have problems with alcohol	16	18	48	24	3	0	0	**75.2%**	**(82)**	**24.8%**	**(27)**
I would feel embarrassed asking patients about their use of alcohol	20	31	44	11	2	1	0	**87.2%**	**(95)**	**12.8%**	**(14)**
People with an alcohol problem can only be effectively treated when they hit 'rock bottom'	38	28	27	8	4	3	1	**86.1%**	**(93)**	**13.9%**	**(15)**
People should have the right to use alcohol as they wish within the confines of their own home	4	8	18	67	7	5	0	**27.5%**	**(30)**	**72.5%**	**(79)**
Alcohol-related harm will be reduced by banning promotions that sell alcohol at below cost price	9	17	41	28	8	5	1	**62.0%**	**(67)**	**38.0%**	**(41)**
The introduction of minimum retail pricing i.e. a minimum price for one unit of alcohol will reduce consumption	13	15	45	29	3	2	2	**68.2%**	**(73)**	**31.8%**	**(34)**
The proposal to raise the minimum legal purchase age for off-sales purchases to 21 years will reduce the negative impact of alcohol on communities	7	23	41	28	5	4	1	**65.7%**	**(71)**	**34.3%**	**(37)**
It will be beneficial to reduce drink drive limit from 80 mg to 50 mg per 100 ml of blood	4	2	15	25	20	41	2	**19.6%**	**(21)**	**80.4%**	**(86)**

challenging area of practice. Health care students may differ in their perceptions of the relative importance of the detail of this health message, but nevertheless feel that they have the ability to intervene successfully. This may explain some of the disparity between the responses of the occupational therapy students; only 58.8% believed that they had the appropriate knowledge to advise about responsible drinking while many more, 86.2%, believed that they had the personal qualities to initiate brief interventions.

The alcohol-related content of the curriculum undertaken by all the students who participated in the study is unknown; this may have differed greatly, and it is likely that it explains part of the disparity in knowledge evident in the findings. Similarly, individual students' practice placement experience in relation to alcohol misuse cannot be reported, and it is acknowledged that this is likely to have varied greatly, from minimal to extensive exposure. Nevertheless, the gaps in knowledge revealed by the findings argue for a basic uniform alcohol content within the occupational therapy undergraduate curriculum to meet the demands of this important area of public health policy. Further debate involving educators and practitioners on how best to address knowledge gaps is to be welcomed if the aims of the College of Occupational Therapists are to be met (Crowder and Forster 2008).

Given the complex issues facing the novice occupational therapy graduate in this area, it is interesting that only 12.8% indicated that they would feel embarrassed about asking clients about their use of alcohol. However, almost twice as many (24.8%) indicated that they would avoid such people in their private life. It is difficult to ascertain the beliefs and values that lead to this view, and further study is required to determine the attitudes of occupational therapy students towards people who misuse alcohol. For example, Table 2 indicates a diverse range of views from the occupational therapy students concerning what actually constitutes problem drinking, the reasons for drinking and the consequences. These diverse comments perhaps indicate a lack of detailed information or insight into knowledge of alcohol problems, which inevitably raises issues for curriculum content for occupational therapy education across Scotland.

In relation to current Scottish policy, 62% of the occupational therapy students disagreed that alcohol-related harm would be reduced by banning promotions, for example, and 68.2% disagreed with the need for minimal retail pricing. There is, therefore, a clear disconnection between the views of occupational therapy students in Scotland and the key strategies of the Scottish Government in managing changing attitudes to alcohol. It is not clear if this disparity is due to a lack of engagement or exposure to knowledge about alcohol policy within their professional education. Alternatively, students have not been exposed to the evidence-based debate leading to the development of this alcohol policy.

Perhaps some insight is offered by the statistic that 72.5% of the occupational therapy students felt that people should have the right to use alcohol as they wish within the confines of their own home. A possible reason for this view may be the philosophy of client-centred practice, which is central to several key conceptual models of practice within occupational therapy, and embedded within the College of Occupational Therapists' (2010) *Code of Ethics and Professional Conduct*. It is, however, disconcerting that a large number of students disagreed with key strategies of Scottish Government policy and seem also to challenge emerging evidence from the general public, which suggests that around 80% linked low price and discounts to an increase in people's drinking (Big Drink Debate 2009).

Any increase to the price of alcohol will have a direct impact on this group, who are identified as having a lack of money due to student loans and funding arrangements. However, these students predominantly belong to age groups linked with high, often potentially hazardous, drinking levels. The possibility of a conflict of interest between personal and professional views, with regard to the impact of an alcohol price increase, should not be ignored.

The study has some obvious strengths. An entire cohort of graduation occupational therapy students in Scotland were approached. Ninety-three per cent of students present at lectures responded, so these results are likely to be representative of Scottish graduating occupational therapy students. No advance warning of the study was given, which arguably could have had a negative impact on attendance. Whilst the gender distribution (95.4% female) is skewed, it is nevertheless closely aligned to the gender distribution of allied health professionals working in Scotland (90% female, 10% male workers; ISD Scotland 2008).

Further research is required to explore in detail the thoughts and views that have influenced the responses of the present cohort, taking a qualitative approach. The extent of exposure to alcohol-related clinical work experience is highly variable, and its influence on knowledge and attitudes is unknown.

Conclusion

This study presents several key messages of relevance to the profession of occupational therapy. This focused questionnaire has revealed key information concerning the knowledge and insight of new occupational therapy graduates entering the workforce in 2009 to issues around the use/misuse of alcohol in Scotland.

There were gaps evident in the knowledge base of these students, particularly around alcohol health guidelines. Given the extent of the current alcohol-related problems within the UK, there is a clear argument suggesting that the content of the present occupational therapy curriculum devoted to alcohol misuse within Scotland be reviewed. While it is encouraging to note the positive attitude of students to the effectiveness of early intervention, the lack of embarrassment when asking patients about their use of alcohol, and a confidence in the importance of the role of their own profession in delivering in this area of clinical practice, this key contribution of occupational therapists was not rated by their fellow allied health professional, nursing, and medical

students. The message for the occupational therapy profession is clear: it must consider how effectively it communicates its role both in academia and in the clinical workplace.

There was a clear disparity between the occupational therapy graduates' views and the key tenets of the Scottish Government's strategy for reducing alcohol-related harm in Scotland. Given the occupational therapy students' age and gender, these findings are perhaps not surprising, but it would be of interest to explore whether these views are maintained once they are practising members of the health care workforce.

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Key findings

- Final year occupational therapy students exhibited gaps in knowledge base surrounding alcohol health guidelines.
- Belief in professional role was evident, but was not identified by fellow health professional students.

What the study has added

The study has highlighted a need for alcohol education at undergraduate and post-qualification level, but also students' positive perceptions of the relevance of their role in addressing alcohol misuse.

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